GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTHBOARD OF NURSING
HEALTH REGULATION AND LICENSING ADNMINISTRATION

REINSTATEMENT OF EXPIRED HOME HEALTH AIDE CERTIFICATION

Thank you for submitting an application to reinstate your Home Health Aide Certification (HHA) in the District of Columbia. In this package you will find the instructions and the application for you to fill out to submit to the Board of Nursing to reinstate your certification. Please read everything carefully before you fill out the application.

Definition of Reinstatement
Reissuance of an expired HHA certificate [The process of making your expired certification active and allow you to work].

Requirements for Reinstatement of Expired Home Health Aide Certification
DC Board of Nursing Home Health Aide regulations state that if a home health aide fails to renew his or her certification, the Board can reinstate the certification if the applicant:

a. Submits a completed reinstatement application and
b. Submits proof (documents/papers) of completion of twelve (12) hours of in-service or continuing education for each year that the certification was active, for a maximum of 24 hours. Each document or paper should have the aide's name, name of the course, and the date completed; and
c. Submit evidence (Completed Employment Attestation Form) of having worked for a minimum of eight (8) hours within the last two years as an HHA under the supervision of a licensed nurse or other licensed health professional.

THE APPLICATION PROCESS

Upon submission of the required application documents, the District of Columbia Board of Nursing will review your application and upon final approval, issue you a certification to practice in the District of Columbia.
If you submit an application that is incomplete or otherwise deficient, Health Regulation Licensing Administration's (HRLA) processing staff will notify you of the deficiencies. If the Board has questions or concerns, you will also be notified.

GENERAL REQUIREMENTS FOR ALL APPLICANTS

All applicants for a nursing license in the District of Columbia shall meet the following requirements:

a. Must be at least 18 years of age; and
b. Must not have been convicted of a crime of moral turpitude which bears directly on the applicant's fitness to be licensed; and

All applicants must submit the following in order to be considered for licensure:

a. A complete and signed application, including required supporting documents; and
b. Two passport-type photos of the applicant's face, measuring approximately 2" x 2" with the applicant's name printed on the back. Home snapshots are not acceptable.

WHERE TO MAIL

Documents should be sent to the following address:

Board of Nursing
P. O. Box 37802
Washington, D.C. 20013

If you have any questions, call HRLA's Customer Service toll free line at 1-877-672-2174 between 8:30 a.m. and 4:30 p.m. EST Monday through Friday. Please read these instructions carefully to facilitate prompt processing of your application. Illegible applications and applications submitted without required signatures or with incorrect fees will be returned in their entirety, including fees. Please print or type all information except signatures.

COMPLETING THE LICENSE APPLICATION

Section 1. Applicant Information

Please read this section carefully. Enter your name, address, social security number and other requested information. If updated check the box provided. If your last active certification was issued in another name, you must provide (with this application) a copy of a legal name change document. Acceptable documents include a marriage certificate, divorce decree, court order or spouse's death certificate.

Section 2. Criminal Background Check (CBC)

If you previously completed a Criminal Background Check (CBC) for the purpose of certification or employment that yielded FBI and State results, you are not required to repeat the CBC.

Section 3. Certification Reinstatement Fee

You may pay the recertification fee by a single check or money order. It is recommended that you pay by check, so that you have proof of payment. Checks or money orders should be made payable to DC Treasurer and submitted with your application packet. Do **NOT** send cash. Please print your name on your check, if it is not pre-printed.

Section 4. Screening Questions:

You must answer all of the questions and attach any required supporting documents
If you answer "yes" to question A: Provide court documents which detail the outcome or current status of the arrest or conviction.
If you answer "yes" to questions B - G: Provide a complete explanation on a separate sheet of paper.
If you answer "no" to question H: Submit document/letter with your name on, name of agency providing in-service or continuing education and number of hours completed. You must provide evidence of having completed twelve (12) hours of in-service or continuing education;
If you answer "no" to question I: Provide letter on business letter head signed by supervising nurse or a pay stub indicating that you have worked as a Home Health Aide for a minimum of eight (8) hours within the last twenty four (24) months under the supervision of a licensed nurse or other licensed health professional.

False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514.

Section 5. Applicant Affidavit

Please be informed that by signing this application you are attesting under penalty of perjury that all information and attached documents are true to the best of your knowledge. False statements or documentation may lead to denial of your recertification by the DC Board of Nursing.

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District of Columbia

DEPARTMENT OF HEALTH – HEALTH REGULATION AND LICENSING ADMINISTRATION

HHA REINSTATEMENT APPLICATION

Please read instructions at the beginning of each section as you complete this form. See Section 2 for special information specific to your license. If you have any questions, call HRLA's Customer Service line Monday through Friday, 8:30 AM to 4:30PM EST at 1-877-672-2174.

A Charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

SECTION 1. APPLICANT INFORMATION – Please provide the information requested below. If updated, check box provided at right. If you are changing your name, you must provide legal documentation for the name change. Acceptable documentation for individuals includes a copy of a marriage certificate, divorce decree, or court order.

Keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify the Board of any address change within 30 days of the change.

PLEASE PRINT **Name change due to: ☐ Marriage ☐ Divorce ☐ Court Order**

Full Name: _____ License Number: _____

Mailing Address: _____ *SSN: _____

City/State/Zip Code: _____ Birth date: _____

Phone: _____ Business Phone: _____

E-mail: _____ Business E-mail: _____

*Pursuant to D.C. Official Code Section 3-1205.5(b) (2001) (Health Occupations Revision Act), **applicants are required to provide a Social Security Number (SSN)** on applications for a professional license.

SECTION 2. CRIMINAL BACKGROUND CHECK (CBC

IF YOU COMPLETED A CBC FOR THE PURPOSE OF LICENSURE THAT YIELDED FBI AND STATE RESULTS, YOU ARE NOT REQUIRED TO REPEAT THE CBC.

REQUIREMENTS FOR REINSTATEMENT

DURING THE PERIOD PRIOR TO RINSTATEMENT HHAs must:

Have completed twelve (12) hours of in-service training or other continuing education within one (1) year before turning in this application.

SECTION 3. REINSTATEMENT FEES

Please check the appropriate box	FEE
A. ☐ HHA Reinstatement	$50.00

Make check or money order payable to DC TREASURER and Mail to:

DC Board of Nursing
P.O. Box 37802
Washington, DC 20013
Phone: 1-877-672-2174
Website: www.doh.dc.gov

SECTION 4. Screening Questions – Applicants MUST answer all of the following questions.

Answer questions A through I by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through G below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this form.

A. **Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.**

Please read the information below carefully before responding to this "yes" or "no" question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).
IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following:

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

YES ☐ **NO** ☐

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

B.	Since your last renewal, have you been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	YES ☐ NO ☐
C.	Since your last renewal:	YES NO
	(1) Have you withdrawn an application for licensure/certification/registration to practice your profession in any jurisdiction?	☐ ☐
	(2) Has any authority or peer review board taken adverse action against your certification status?	☐ ☐
	(3) Have you been or are you currently being investigated by any authority or peer review board for any violation of state, federal, or local law?	☐ ☐
	(4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?	☐ ☐
D.	Do you have a physical or mental condition that currently impairs your ability to practice your profession?	YES ☐ NO ☐
E.	Since your last renewal, have you been diagnosed or treated for substance abuse?	YES ☐ NO ☐
F.	Since your last renewal, have you been involved in a malpractice suit? If yes, provide date of incident, allegation, and disposition of case.	YES ☐ NO ☐
G.	Since your last renewal, have you ever been terminated or asked to resign from employment?	YES ☐ NO ☐
H.	**Have you worked as HHA for a minimum of 8 hours within the last 24 months? (Please submit attached Attestation Form)**	YES ☐ NO ☐
I.	**Completed 12 hours of In-service/Continuing Education within the 24 months?**	YES ☐ NO ☐

SECTION 5. APPLICANT AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

_____ _____ _____
APPLICANT SIGNATURE APPLICANT NAME (Please print) DATE

Please keep a copy of this Reinstatement application and your payment for your records.

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.

Government of the District of Columbia

Health Regulation & Licensing
Administration
District of Columbia Board of Nursing

HOME HEALTH AIDE (HHA)

EMPLOYMENT ATTESTATION FORM

Name of HHA_____

HHA Number _____

Name of Facility _____

Name of HHA_____

HHA Number _____

Name of Facility _____

Address_____

Supervising Nurse Name _____

RN Number _____

I, this APPLICANT'S SUPERVISING NURSE, confirm that to the best of my knowledge that this HHA applicant has provided a minimum of eight (8) hours of patient care with the past two years: __ Yes __ No

By signing this attestation,

Supervisor Nurse Name/Signature _____Date _____

HHA Name/Signature_____Date _____

I, hereby attest that the information provided on this HHA Audit Attestation Form is true and complete to the best of my knowledge. I understand that making a false statement on this document may result in the Board of Nursing taking any action against me that it deems appropriate.